WORKERS' COMPENSATION FORM

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT WITH THE ATTORNEY.

INFORMATION ABOUT YOU

Name:_____ Male or Female

Home address: _____

City: _____ State: _____ Zip code:_____

Home phone number: (_____) _____

Work phone number: (_____) _____

Cell phone number: (_____) _____

Social Security number: _____-_____-_____ Date of Birth:_____

Marital status _____ Spouse's name:_____

Number of Children under 18:_____

Child's Name:_____ Age_____ Relationship_____

Child's Name:_____ Age_____ Relationship_____

Child's Name:_____ Age_____ Relationship_____

Child's Name:_____ Age_____ Relationship_____

INFORMATION ABOUT YOUR EMPLOYMENT AT THE TIME OF INJURY

Name of Employer:_____

Employer's address: _____

City: _____ State: _____ Zip code: _____ Phone: (____) _____

Length of employment: _____ Start date: _____ Years: _____

Job title: _____

Job Duties: _____

Your immediate supervisor: _____

Number of hours per week you worked before the injury:

Regular: _____ Hourly rate: _____

Overtime hours per week: _____

Gross earnings per week (before taxes): $_____

Union?_____ If yes, which union and which local? _____

Did you have a second job at the time of your injury? Yes or No

If yes, with what company? _____

Was your employer aware of your second job? Yes or No

Gross earnings per week (before taxes) from your second job:_____

Present employer, if different from above: _____

Name of your employer's workers' compensation insurance carrier at the time of your injury: _____

Address:_____ City: _____

State: _____ Zip code: _____ Claim number: _____

Adjuster: _____ Phone number: (_____) _____

INFORMATION ABOUT YOUR INJURY OR ILLNESS

Date of injury: _____ Time of day: _____ AM or PM

Location of accident (plant, office, etc.) _____

City: _____ State: _____ County: _____ Zip code: _____

Did you report the accident to your employer? Yes or No

If yes, when? _____ To Whom? _____ What is/was their position with your employer? _____ Did you report the accident in writing? Yes or No

Witnesses:_____

_____

_____

Describe how you were injured: _____

_____

_____

_____

_____

What parts of your body were injured? (Please specify right, left, etc.) _____

_____

_____

Did you have any broken bones from this accident? Yes or No

If yes, which bones were broken? _____

What physical complaints do you have currently? _____

_____

_____

_____

_____

INFORMATION ABOUT YOUR MEDICAL TREATMENT

Did you go to the hospital because of this injury? Yes or No

Name of Hospital #1: _____

Complete mailing address: Street or P.O. Box _____

City: _____State: _____ Zip Code:_____

Telephone Number: _____

Inpatient Stays: Date admitted: _____ Date released: _____

Reason for Inpatient Stay: _____

Treatment received at Inpatient stay: _____

Outpatient Visits: Dates _____

Reason for Outpatient Visit: _____

Treatment received at Outpatient Visit: _____

Emergency Room Visits: Dates _____

Reason for ER Visit: _____

Treatment received at ER Visit: _____

Name of Hospital #2: _____

Complete mailing address: Street or P.O. Box _____

City: _____State: _____ Zip Code:_____

Telephone Number: _____

Inpatient Stays: Date admitted: _____ Date released: _____

Reason for Inpatient Stay: _____

Treatment received at Inpatient stay: _____

Outpatient Visits: Dates _____

Reason for Outpatient Visit: _____

Treatment received at Outpatient Visit: _____

Emergency Room Visits: Dates _____

Reason for ER Visit: _____

Treatment received at ER Visit: _____

Name of Hospital #3: _____

Complete mailing address: Street or P.O. Box _____

City: _____State: _____ Zip Code:_____

Telephone Number: _____

Inpatient Stays: Date admitted: _____ Date released: _____

Reason for Inpatient Stay: _____

Treatment received at Inpatient stay: _____

Outpatient Visits: Dates _____

Reason for Outpatient Visit: _____

Treatment received at Outpatient Visit: _____

Emergency Room Visits: Dates _____

Reason for ER Visit: _____

Treatment received at ER Visit: _____

Name and address of the doctors you have seen for this injury:

Name of Healthcare Provider #1: _____

Complete mailing address: Street or P.O. Box _____

City: _____State:_____ Zip Code:_____

Telephone Number: _____

Approximate Date you first saw this healthcare provider: _____

Approximate Date you last saw this healthcare provider: _____

Do you have another appointment scheduled to see this healthcare provider? If so, please list the date: _____

What was the reason for your last visit to this healthcare provider? _____

_____

What treatment was received? _____

Name of Healthcare Provider #2: _____

Complete mailing address: Street or P.O. Box _____

City: _____State: _____ Zip Code:_____

Telephone Number: _____

Approximate Date you first saw this healthcare provider: _____

Approximate Date you last saw this healthcare provider: _____

Do you have another appointment scheduled to see this healthcare provider? If so, please list the date: _____

What was the reason for your last visit to this healthcare provider? _____

_____

What treatment was received? _____

Name of Healthcare Provider #3: _____

Complete mailing address: Street or P.O. Box _____

City: _____State: _____ Zip Code:_____

Telephone Number: _____

Approximate Date you first saw this healthcare provider: _____

Approximate Date you last saw this healthcare provider: _____

Do you have another appointment scheduled to see this healthcare provider? If so, please list the date: _____

What was the reason for your last visit to this healthcare provider? _____

_____

What treatment was received? _____

If you need more space to list additional Healthcare Providers please use a separate sheet of paper and list the same information that is requested above.

Did you receive Physical Therapy? Yes or No

If yes, where? _____

Have any of your doctors released you to return to work? Yes or No

If yes, which doctor:_____

Did he place any restrictions on you returning to work? Yes or No

If yes, what are the restrictions?_____

_____

Have you been released from active medical care? Yes or No

If not, form which doctors are you still receiving active treatment?

_____

_____

Do you have any prior injuries or illnesses? If so, please describe injury or illness and approximate date. _____

_____

_____

_____

<u>INFORMATION ABOUT YOUR WORKERS' COMPENSATION BENEFITS</u>

Did you lose any time from work because of your injury? Yes or No

If yes, how much time did you lose from work? _____

From:_____ To: _____

Did your employer or their insurance company pay you money for the time you missed? Yes or No

If yes, how much were you paid per check? _____ Are you still receiving payments? Yes or No

Were you placed on light-duty employment by your employer when you returned to work? Yes or No

If yes, what type of light duty were you given, and for how long? _____

_____

_____

Is there anything else you would like to tell us about yourself? _____

_____